4 Obtaining Prior Authorization

Prior authorization serves as a cost-monitoring, utilization review measure and quality assurance mechanism for the Alabama Medicaid program. Federal regulations permit the Alabama Medicaid Agency to require prior authorization (PA) for any service where it is anticipated or known that the service could either be abused by providers or recipients, or easily result in excessive, uncontrollable Medicaid costs.

This chapter describes the following:

- Identifying services requiring prior authorization
- Submitting a prior authorization request
- Receiving approval or denial of the request
- Using AVRS to review approved prior authorizations
- Submitting claims for prior authorized services

4.1 Identifying Services Requiring Prior Authorization

The Alabama Medicaid Agency is responsible for identifying services that require prior approval. Prior authorization is generally limited to specified non-emergency services. The following criteria may further limit or further define the conditions under which a particular service is authorized:

- Benefit limits (number of units or services billable for a recipient during a given amount of time)
- Age (whether the procedure, product, or service is generally provided to a recipient based on age)
- Sex (whether the procedure, product, or service is generally provided to a recipient based on gender)

To determine whether a procedure or service requires prior authorization, access the Automated Voice Response System (AVRS). Refer to Section L.6, Accessing Pricing Information, of the AVRS Quick Reference Guide (Appendix L) for more information.

The program services chapters in Part II of this manual may also provide program-specific prior authorization information.

NOTE:

When a recipient has third party insurance and Medicaid, prior authorization must be obtained from Medicaid if an item ordinarily requires prior authorization. This policy does not apply to Medicare/Medicaid recipients.

4.2 Submitting a Prior Authorization Request

To receive approval for a PA request, you must submit a complete request using one of the approved submission forms. This section describes how to submit online and paper PA requests, and includes the following sections:

- Submitting PAs (278 Health Care Services Review- Request for Review and Response) using Provider Electronic Solutions
- Submitting Paper PA Requests

NOTE:

PAs are approved only for eligible recipients. It is therefore recommended that provider verify recipient eligibility prior to submitting a PA request. Refer to Chapter 3, Verifying Recipient Eligibility, for more information.

In the case of a retroactive request (retroactive eligibility), the recipient must have been eligible on the date of service requested. The provider must submit the PA request within 90 calendar days of the retroactive eligibility award (issue) date. If a retroactive PA request is submitted and does not reference retroactive eligibility, the request will be denied.

4.2.1 Submitting PAs Using Provider Electronic Solutions

Beginning December 1, 1999, you can submit electronic PA requests using EDS Provider Electronic Solutions software, available to you at no charge. If you already use this software, you will be mailed an upgrade; if you do not currently use the software, but would like to order a copy, refer to Appendix B, Electronic Media Claims Guidelines, for contact information. The electronic 278 Health Care Services Review- Request for Review and Response claim is not limited to the use of the Provider Electronic Software. Providers may use other vendor's software to submit a 278 electronic claim.

Electronic claims and PA submission saves time and money.

4.2.2 Submitting Paper PA Requests

In the absence of electronic applications, providers may submit requests for prior authorization using the Alabama Prior Review and Authorization Request Form. No other form or substitute will be accepted. Completed requests should be sent to the following address:

EDS Prior Authorization Unit
P.O. Box 244032
Montgomery, AL 36124-4032.

4.3 Completing the Alabama Prior Review and Authorization Request Form

Providers use the Alabama Prior Review and Authorization Request Form to submit non-dental PAs on paper. These forms are available through the Medicaid Agency.

4.3.1 Blank Alabama Prior Review and Authorization Request Form

ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

(Required If Medicaid Provider) PMP ( )
Requesting Provider
License # or Provider # _____
Phone ( ) _____
Name _____

Recipient Medicaid Number_____
Name _____
Address _____
City/State/Zip _____

Rendering Provider Medicaid # _____
Phone ( )_____
Fax ( )_____
Name _____
Address _____
City/State/Zip _____

Date of EPSDT Screening CCYYMMDD _____DOB_____
Date of Prescription CCYYMMDD _____
First Diagnosis _____ • ____ Ambulance Transport Code ____
Second Diagnosis _____ • ____ Ambulance Transport Reason Codes ____
PA Type_____ Patient Condition _____

(01) Durable Medical Equipment	(06) Physical Therapy	(12) Medical	(18) Inpatient Stay *
(02) Eyeglasses	(07) Speech Therapy	(13) Psychiatric*	(19) Other
(03) Home Health	(08) Private Duty Nursing	(15) Surgical	(20) Living at Home Waiver
(04) Transportation	(09) Ultrasound	(16) Oxygen	
(05) Occupational Therapy	(10) Targeted Case Mgt.	(17) Prosthetic Devices	

Line Item	DATES OF SERVICE START CCYYMMDD	STOP CCYYMMDD	PLACE OF SERVICE	PROCEDURE CODE*	MODIFIER 1	UNITS	PRICE/ DOLLARS

Clinical Statement: (Include Prognosis and Rehabilitation Potential) A current plan of treatment and progress notes, as to the necessity, effectiveness and goals of therapy services (PT, OT, RT, SP, Audiology, Psychotherapy, Oxygen Certifications, Home Health and Transportation) must be attached.

_____
_____
_____
_____
_____
_____

*** If this PA is for Psychiatric or Inpatient stay, Procedure Code is not required.**

Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient and that a physician signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Provider_____ Date_____

FORWARD TO: EDS, P.O. Box 244032 Montgomery, Alabama 36124-4032

Form 342
Revised 07/26/04

Alabama Medicaid Agency

4.3.2 Instructions for completing the Alabama Prior Review and Authorization Request Form

Section 1: Requesting Provider Information (Required)

License # or Provider #	Enter the license number or the nine-digit Medicaid provider number of the physician requesting or prescribing services.
Phone	Enter the current area code and telephone number for the requesting physician.
Name	Enter the name of the prescribing physician.
PMP	Check if the patient has been assigned to a Primary medical provider (PMP) under the Primary Care Case Management (PCCM) program, known as Patient 1st.

Section 2: Rendering Provider Information (Required)

Medicaid Provider Number	Enter the nine-digit Medicaid provider number of the provider rendering services.
Phone	Enter the current area code and telephone number for the provider rendering services.
Fax	Enter the current area code and fax number for the provider rendering services.
Name	Enter the name of the provider rendering services.
Address	Enter the physical address of the provider rendering services
City/State/Zip	Enter the city, state, and zip code for the address of the provider rendering services
Certification	N/A
Recertification/ continued stay	N/A

Section 2.a: 278 Electronic Certification Type (Required)

Certification Type Code	**Certification Type Code Description**
1	Appeal – Immediate
2	Appeal – Standard
3	Cancel
4	Extension
I	Initial
R	Renewal
S	Revised

Section 3: Recipient Information (Required)

Recipient Medicaid Number	Enter the 13-digit RID number.
Name	Enter the recipient's full name as it appears on the Medicaid eligibility transaction.
Address	Enter the recipient's current address
City/State/Zip	Enter the city, state, and zip code for the address of the recipient

Section 4: Other Information

Date of EPSDT Screening CCYYMMDD	**Required field for all requests.** Enter the date of the last EPSDT screening. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001
Date of Prescription CCYYMMDD	**Required field for all requests.** Enter the date of the prescription from the attending physician. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001
First Diagnosis	**Required field for all requests.** Enter the primary diagnosis code.
Second Diagnosis	Enter the secondary diagnosis code.
Ambulance Transport Code	Enter code to specify the type of ambulance transportation. Refer to "Ambulance Transport Codes" in the section below for appropriate codes. **Used for ambulance services only.**
Ambulance Transport Reason Code	Enter code to specify the reason for ambulance transportation. Refer to "Ambulance Transport Reason Codes" in the section below for appropriate codes. **Used for ambulance services only.**
Patient Condition	Enter the code that best describes the patient's condition. Refer to "Patient Condition Codes" in the section below for appropriate codes. **Used for ambulance services and DME providers only.**
PA Type	**Required field for all requests.** Outpatient hospitals requesting physical therapy must use PA type 12 (medical) and not PA type 06 (physical therapy.) This field is no longer required on an electronic (278) claim (Still trying to determine if PA Type still applicable for paper)

Section 5: Procedure Information (Required)

Dates of Service	Enter the line item (1, 2, 3, etc) along with start and stop dates requested. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001.
Procedure Code	Enter the five-digit procedure code requiring prior authorization. If this PA is for inpatient stay, a procedure code is not required.
Modifier 1	Enter modifier, if applicable.
Units	Enter total number of units.
Price/Dollars	Enter price in dollars.
Clinical Statement	Provide a clinical statement including the current prognosis and the rehabilitation potential as a result of this item or service. Be very specific.
Signature of requesting provider	After reading the provider certification, the provider signs the form. In place of signing the form, the provider or authorized representative initials the provider's stamped, computer generated, or typed name, or indicate authorized signature agreement on file.
Date	Enter the date of the signature

NOTE:

Additional information may be required depending on the type of request.

Procedure Code Modifiers

Procedure code modifiers are not available with the current electronic 278 Health Care Services Review – Request for Review transaction. If procedure code modifiers are necessary for a claim to process correctly, providers may submit a paper PA form.

Ambulance Transport Codes (Ambulance Services Only)

Use this table for the appropriate code to describe the type of trip for ambulance service requests.

Code	*Description*
I	Initial Trip
R	Return Trip
T	Transfer Trip
X	Round Trip

Ambulance Transport Reason Codes (Ambulance Services Only)

Use this table for the appropriate code to describe the reason for the ambulance transport request.

Code	*Description*
A	Patient was transported to nearest facility for care of symptoms.
B	Patient was transported for the benefit of a preferred physician
C	Patient was transported for the nearness of family member
D	Patient was transported for the care of a specialist or for availability of specialized equipment
E	Patient transferred to rehabilitation facility

Patient Condition Codes

Use this table for the appropriate code to describe the condition of the patient at the time of ambulance transport.

Code	*Description*
01	Patient was admitted to a hospital
02	Patient was bed confined before the ambulance service
03	Patient was bed confined after the ambulance service
04	Patient was moved by stretcher
05	Patient was unconscious or in shock
06	Patient was transported in an emergency situation
07	Patient had to be physically restrained
08	Patient had visible hemorrhaging
09	Ambulance service was medically necessary
10	Patient is ambulatory
11	Ambulation is impaired and walking aid is used for therapy or mobility
12	Patient is confined to a bed or chair
13	Patient is confined to a room or an area without bathroom facilities
14	Ambulation is impaired and walking aid is used for mobility
15	Patient condition requires positioning of the body or attachments which would not be feasible with the use of an ordinary bed
16	Patient needs a trapeze bar to sit up due to respiratory condition or change body positions for other medical reasons
17	Patient's ability to breathe is severely impaired
18	Patient condition requires frequent and/or immediate changes in body positions
19	Patient can operate controls
20	Side rails are to be attached to a hospital bed owned by the beneficiary
21	Patient owns equipment
22	Mattress or side rails are being used with prescribed medically necessary hospital bed owned by the beneficiary
23	Patient needs lift to get in our out of bed or to assist in transfer from bed

Code	*Description*
	to wheelchair
24	Patient has an orthopedic impairment requiring traction equipment which prevents ambulation during period of use
25	Item has been prescribed as part of a planned regimen of treatment in patient's home
26	Patient is highly susceptible to decubitus ulcers.
27	Patient or a care-giver has been instructed in use of equipment

4.4 Completing the Alabama Prior Review and Authorization Dental Request Form

Providers use this form to submit dental PAs on paper. These forms are available through the Alabama Medicaid Agency.

Replaced Form

4.4.1 Blank Alabama Prior Review and Authorization Dental Request Form

Section I – Must be completed by a Medicaid provider.
Requesting Provider License No. _____
Phone( ) _____
Name_____
Address_____
City/State/Zip_____
Provider Medicaid Number _____

Section II
Medicaid Recipient Identification Number _____
(13-digit RID number is required.)
Name as shown in Medicaid system _____
Address _____
City/State/Zip _____
Telephone Number _____

Section III DATES OF SERVICE START CCYYMMDD	STOP CCYYMMDD	REQUIRED PROCEDURE CODE	QUANITY REQUESTED	TOOTH NUMBER(S) OR AREA OF THE MOUTH
PLACE OF SERVICE (Circle one)				
11 = DENTAL OFFICE				
22 = OUTPATIENT HOSPITAL				
21 = INPATIENT HOSPITAL				

Section IV
1. Indicate on the diagram below the tooth/teeth to be treated.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

2. Detailed description of condition or reason for the treatment:

_____

_____

3. Brief Dental/Medical History:_____

_____

_____

NOTE :When x-rays or photos are required per criteria, please send them in a separate, sealed envelope marked “Confidential.” Make sure the recipient’s name and Medicaid number are included with the X-rays or photos.
Certification Statement: This is to certify the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient. This Form and any statement on my letterhead attached hereto have been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Dentist_____ Date of Submission_____

FORWARD TO: EDS, P.O. Box 244032, Montgomery, Alabama 36124-4032
Form 343 05/05 Alabama Medicaid Agency

4.4.2 Instructions for Completing the Alabama Prior Review and Authorization Dental Request Form

Deleted: ~~physician~~
Added: dental provider
Deleted: ~~prescribing physician~~
Added: dental provider

Deleted: ~~Date of EPSDT Screening CCYMMDD~~
Added: Telephone Number
Deleted: ~~Enter the date… would be 19991001~~
Added: Enter the recipient's most current phone number.

Deleted: ~~Example: October 1, 1999 would be 19991001.~~
Added: Use the date…20051001 (October 1, 2005).

Deleted: ~~Enter~~
Added: Circle
Added: Use the correct CDT2005 procedure code.
Deleted: ~~Units~~
Added: Quantity Requested
Deleted: ~~total units~~
Added: the, time the procedure code will be used/billed.

Deleted: ~~Price/Dollars~~
Added: Tooth Number, the tooth number(s) or…procedure code requested.
Deleted: ~~price in dollars.~~

Deleted: ~~4~~
Added: 3
Added: If x-rays are…and Medicaid number.

Deleted: ~~Section 5:Tooth Information~~

Section 1: Requesting Provider Information (Required)

License #	Enter the license number of the physician requesting or prescribing services.
Phone	Enter the current area code and telephone number for the requesting dental provider.
Name	Enter the name of the dental provider.
Provider Medicaid Number	Enter the nine-digit Medicaid provider number of the requesting provider.

Section 2: Recipient Information (Required)

Recipient Medicaid Number	Enter the 13-digit RID number.
Name	Enter the recipient's full name as it appears on the Medicaid eligibility transaction.
Address	Enter the recipient's current address
City/State/Zip	Enter the city, state, and zip code for the address of the recipient
Telephone Number	Enter the recipient's most current phone number.

Section 3: Procedure Information

Dates of Service	Enter the start and stop dates of service requested. Enter dates using the format CCYYMMDD. Use the date you complete the form and add six months. For example, 20050401 (April 1, 2005) through 20051001(October 1, 2005).
Place of Service	Circle the appropriate two-digit place of service.
Procedure Code	Enter the five digit procedure code requiring prior authorization. Use the correct CDT2005 procedure code.
Quantity Requested	Enter the number of times the procedure code will be used/billed.
Tooth Number	Enter the tooth number(s) or area of the mouth in relation to the procedure code requested.

Section 4: Medical Information

Complete Items 1-3 with the information requested. Documentation must be legible. If x-rays are sent, place them in a separate sealed envelope marked with recipient's name and Medicaid number.

Indicate whether the recipient has missing teeth and indicate the missing teeth with an X on the diagram.

After reading the provider certification, the provider signs and dates the form. In place of signing the form, the provider or authorized representative initials the provider's stamped, computer generated, or typed name, or indicate authorized signature agreement on file.

The completed form should be forwarded to EDS at the address given on the form.

4.5 Receiving Approval or Denial of the Request

Letters of approval will be sent to the provider on paper requests only, indicating the approved ten-digit PA number, dates of service, place of service, procedure code, modifiers, and authorized units or dollars. This information should be used when filing the claim form. All electronic claims (278) will generate a 278 Health Care Services Review – Response, to notify the requester that of the response. Once the State has made a decision on the request, which will trigger an electronic 278 response to the provider. The electronic 278 response will either contain the PA number, rejection code or cancellation code information.

Section 1: Decision Codes

Current Decision Codes:		HIPAA Decision Codes:	
A	Approved	X	Cancelled
P	Pending	Z	Rejected
D	Denied		
H	Pending Hearing/Appeal		
M	Modified PA Request		
C	Condition Approval		
R	Denial after Appeal		
S	Sent back for Corrections (Used by EDS in Paper Process only)		

Letters of denial will also be sent to the provider and recipient indicating the reason for denial, for paper claims only.

Requests for reconsideration of a denied request may be sent with additional information that justifies the need for requested service(s). The Alabama Medicaid Agency must receive this request for appeal within 30 days from the date of the denial letter, or the decision will be final and no further review will be available.

4.6 Using AVRS to Review Approved Prior Authorizations

AVRS allows the provider to access information about an approved prior authorization number to confirm start and stop dates, procedure code(s), total units, and dollar amount authorized.

To inquire about approved prior authorizations (PAs), press 6 (the number 6) from the main menu. AVRS prompts you for the following:

- Your Alabama Medicaid provider number, followed by the pound sign
- The ten-digit prior authorization number, followed by the pound sign

AVRS performs a query and responds with the following information for the PA:

- Recipient number
- Procedure code or NDC, if applicable (some PAs do not require procedure codes or NDCs)
- Start and stop dates

- Units authorized
- Dollars Authorized
- Units used
- Dollars Used

When the response concludes, AVRS provides you with the following options:

- Press 1 to repeat the message
- Press 2 to check another Procedure Code or NDC for the same provider
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

4.7 Submitting Claims for Prior Authorized Services

Once the **approved** ten-digit PA has been received, providers must indicate that number on the claim form in the appropriate spaces. Claims for services that require a PA received by EDS without the ten-digit PA number are denied. Refer to Chapter 5, Filing Claims, for more information on completion of the claim form.

NOTE:

Providers must also have the appropriate Patient 1st referral for certain patients and/or services. Refer to Chapter 39.

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